Appendix 2

Universal Newborn Hearing Screening Program
Facility Staffing Form

FACILITY NAME: _____

PROGRAM DIRECTOR: _____

ADDRESS: _____
_____
_____

PHONE #: _____ FAX #: _____
TTY #: _____ E-MAIL: _____

ALTERNATE PROGRAM
DIRECTOR CONTACT: _____ PHONE #: _____

PROGRAM AUDIOLOGIST: _____

ADDRESS: _____
_____
_____

MA PROFESSIONAL LICENSE #: _____

PHONE #: _____ FAX #: _____
TTY #: _____ E-MAIL: _____

BIRTH REGISTRAR OR
BIRTH CERTIFICATE
CONTACT PERSON: _____

ADDRESS: _____
_____
_____

PHONE #: _____ FAX #: _____
TTY #: _____ E-MAIL: _____

PHYSICIAN CONTACT: _____

PHONE #: _____ FAX #: _____
TTY #: _____ E-MAIL: _____

REPORT CONTACTS

PRIMARY REPORT CONTACT: _____

ADDRESS: _____
_____
_____

PHONE #: _____ FAX #: _____

SECONDARY REPORT CONTACT: _____

ADDRESS: _____
_____
_____

PHONE #: _____ FAX #: _____

MDPH ON-SITE CONTACT

PHONE #: _____ FAX #: _____
TTY #: _____ E-MAIL: _____

SCREENING INFORMATION

SCREENING TECHNOLOGY USED (e.g., OAE, ABR, OAE/ABR combined):

IN WELL BABY NURSERY:_____

IN SCN/NICU:_____

OUTPATIENT RESCREENS PERFORMED:

YES ☐ NO ☐